



**U.S. Department of Labor**

Office of Administrative Law Judges  
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**Issue date: 14Jun2001**

CASE No.: 2000-BLA-00112

In the Matter of:

PETER J. STRICEK  
Claimant

v.

BETH ENERGY MINES INC.  
Employer

and

DIRECTOR, OFFICE OF WORKERS'  
COMPENSATION PROGRAMS  
Party-In-Interest

Appearances:

Helen M. Koschoff, Esquire  
For the Claimant

Maureen Calder, Esquire  
For the Employer

Before: Ainsworth H. Brown  
Administrative Law Judge

**DECISION AND ORDER DENYING BENEFITS  
ON MODIFICATION**

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq (the Act). The Act provides benefits to persons totally disabled due to pneumoconiosis and to certain survivors of persons who had pneumoconiosis and were totally disabled at the time of their death or whose death was caused by pneumoconiosis. Pneumoconiosis is a chronic dust disease of the lungs, including respiratory and pulmonary impairments arising out of coal mine employment, and is commonly referred to as black lung.

On November 4, 1999, the Director, Office of Workers' Compensation Programs referred this case to the Office of Administrative Law Judges for a formal hearing. DX-62. A hearing was held before me in Reading, Pennsylvania on June 26, 2000, at which time all parties were given a full opportunity to present evidence<sup>1</sup> and argument as provided in the Act and the Regulations issued thereunder, found at Title 20, Code of Federal Regulations.

At the hearing, Claimant made the following objections to the Director's exhibits: (1) DX-26 was missing the x-ray interpretations by Drs. Laucks, Duncan and Sobel of the 11-7-97 x-ray (there was a cover sheet with no reports attached); (2) the exhibits jumped from DX-29-B-34 to DX-29-29; and (3) exhibits previously stricken by Judge Romano (i.e. 7-10-98 deposition of Dr. Dittman, reports of Drs. Levinson and Kaplan regarding their review of 6-25-98 ventilation studies were still part of the record. I overruled Claimant's motion to strike noting that this was a modification with emphasis on the newly developed evidence. Nevertheless, I allowed Claimant's objections to remain on the record. TR 9. Director's Exhibits 1 through 62 were admitted into evidence. TR 10.

Claimant offered exhibits 1 through 46 for admission into evidence. After an objection by Employer, Claimant agreed to withdraw CX-14, 16, 18, 20, and 41. TR 10-11. Employer also objected to new x-ray readings of old x-rays (CX-7, 8, 36 through 39). At that time I noted 20 C.F.R. §725.456 restrains parties from going back and redoing old evidence. Nevertheless, I agreed to allow the documents to remain for appellate review while noting a concern about their probative value. TR 12-13. With that caveat, Claimant's exhibits 1 through 13, 15, 17, 19, 21 through 40, and 42 through 46 are admitted into evidence.<sup>2</sup>

Employer's exhibits 1 through 16 were admitted into evidence. TR 20. Both Claimant and Employer were granted an enlargement of time to submit additional medical evidence post-hearing. Employer filed a post-hearing brief on March 1, 2001.

## ISSUES

Claimant has been credited with 22 years of qualifying coal mine employment. This issue is therefore not contested. TR 20. The following are at issue in this case, however:

- (1) whether Claimant has pneumoconiosis;
- (2) whether Claimant's pneumoconiosis arose out of coal mine employment;
- (3) whether Claimant suffers from a totally disabling pulmonary or respiratory impairment;

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<sup>1</sup> The following references will be used herein: TR for transcript, CX for Claimant's exhibit, DX for Director's exhibit, and EX for Employer's exhibit.

<sup>2</sup> Claimant submitted exhibits 47 through 49 post-hearing. These exhibits are admitted into evidence.

- (4) whether Claimant's total disability is due to pneumoconiosis;
- (5) whether Claimant has established a mistake of fact or a change in condition<sup>3</sup>; and
- (6) whether reopening this claim on modification would render justice under the Act.

For the reasons stated herein, I find that Claimant has failed to establish entitlement to benefits on modification. Claimant has failed to adduce persuasive evidence that the previous denial of benefits constitutes a mistake in determination of fact (Claimant agreed at the hearing that there was not a mistake in fact) or that the record supports a change in condition. I therefore conclude that reopening this claim on modification on the basis of a mistake in determination of fact would not render justice under the Act, and that Claimant has failed to establish a change in conditions.

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

### Background and Procedural History

Peter J. Stricek, Claimant, was born on September 13, 1923. DX-7. He was married to Rose M. Jabbo Stricek on June 5, 1949. DX-9. Claimant's wife, Rose, recently passed away. TR 23. He has no other dependents for purposes of augmentation of benefits under the Act.

While this case was pending a decision, new Federal Regulations were promulgated. Subsequently, there was litigation contesting their liability. On February 23, 2001, I issued an Order requiring the parties to submit a brief regarding the issue of whether specific regulations, i.e. 20 C.F.R. §§718.104(d), 718.201(a)(2), 718.201(c), 718.204(a), 718.205(c)(5) and 718.205(d), would affect the outcome of the current litigation. On March 14, 2001, Claimant submitted a response indicating that the new regulations would not affect the outcome of this case. On March 19, 2001, Employer submitted a response that the amended regulations may affect the outcome of the case. On March 22, 2001, I issued an Order Denying Request for Stay finding that the new regulations would not have an impact on the instant adjudication.

This claim has an extensive procedural history. Claimant filed his first claim for black lung benefits on June 30, 1973. DX-29B-23. The claim was denied by the Social Security Administration on December 31, 1973, May 15, 1974, September 13, 1978, and February 22, 1979. The claim was then transferred to the Department of Labor for review. Said claim was denied on February 25, 1981 noting Claimant's current coal mine employment. Claimant advised he did not want to pursue the claim further since he continued to work in coal mining. DX-29B-23.

Claimant filed a second claim for benefits on August 4, 1987. DX-29B-1. This claim was initially denied by the District Director on November 30, 1987. DX-29B-16. I conducted a formal hearing on January 4, 1989. DX-29B-33. On April 12, 1989, I

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<sup>3</sup> At the hearing, Claimant advised the Court he was not pursuing the mistake of fact prong of the modification analysis. TR 21.

issued a Decision and Order Denying Benefits finding that Claimant had failed to establish the existence of pneumoconiosis. DX-29B-34.

Claimant filed a third claim for benefits on March 27, 1992. DX-29A-1. This claim was initially denied by the District Director on June 24, 1992. DX-29A-14. Administrative Law Judge (ALJ) Frank D. Marden conducted a formal hearing on June 15, 1993. DX-29-70. On April 29, 1994, ALJ Marden issued a Decision and Order Denying Benefits finding that the existence of pneumoconiosis had not been established. DX-29-71. Claimant filed a Request for Modification on February 21, 1995. DX-29-72. This request was denied by the District Director on July 10, 1995. DX-29-83. Claimant timely requested a hearing but then subsequently withdrew his claim. DX-29-90. Judge Marden issued a Decision and Order Approving the Withdrawal of Claim on February 7, 1996. DX-29-96.

Claimant filed a fourth claim for benefits on July 18, 1997. DX-1. This claim was denied by the District Director on October 22, 1997. DX-15. A formal hearing was held before ALJ Ralph A. Romano. On February 3, 1999, Judge Romano issued a Decision and Order Denying Benefits finding that Claimant had failed to establish the existence of pneumoconiosis. DX-51. Claimant filed a Request for Modification on April 5, 1999. DX-52. Said request was denied by the District Director on July 29, 1999. DX-58. Claimant requested a formal hearing.

At the hearing, Claimant testified he was 76 years old and that his wife had died six months previously. TR 23. He has not worked since the last hearing. TR 23. Claimant noted he has not smoked and has he has not been hospitalized since the last hearing. TR 24. He stated he could only walk one block or walk up seven steps before becoming "winded." TR 24. He testified he continues to treat with Drs. Raymond and Matthew Kraynak every two months for his breathing problem. He also treats with Dr. Nuschke. TR 25. Claimant added that his high blood pressure was under control. He spends most of his time sitting on his porch. TR 25. Claimant stated he would not be able to work in a coal mine due to his breathing problems. TR 26. He added he does not have a heart problem and he has experienced an increase in his coughing with sputum production since the last hearing. TR 26. Claimant testified he smoked one pack of cigarettes per day from age 19 to 1968 with an 8 year break in between. TR 27. He added he has arthritis and is on medication for gout. TR 28. He also uses an inhaler and takes high blood pressure medication. TR 29.

#### Standard for Modification

Section 22 of the Longshore and Harbor Workers' Compensation Act provides in part that

Upon his own initiative, or upon the application of any party ... on the ground of a change in conditions or because of a mistake in a determination of fact ... the [fact-finder] may, at any time ... prior to one year after the rejection of a claim, review a compensation case ...

33 U.S.C. §922, as incorporated by 30 U.S.C. §932(a) and implemented by 20 C.F.R. §725.310.

In every instance, the party who petitions for modification bears the burden of proof. *Metropolitan Stevedore Co. v. Rambo*, 521 U.S. 121, 138-39 (1997) (*Rambo II*); *Greenwich Collieries v. Director, OWCP*, 990 F.2d 730, 736, 17 BLR 2-64 (3d Cir. 1993), *aff'd* 512 U.S. 267 (1994).

With this in mind, I turn to the merits of Claimant's Request for Modification. While this decision is based on a *de novo* review and consideration of the administrative record as a whole, not all of the evidence that has been introduced prior to the instant request for modification, and has been set forth in the prior Decisions, may again be listed except as required for an analysis of the current request for modification. See *generally Wheeler v. Apfel*, 224 F.3d 891, 895 n.3 (8<sup>th</sup> Cir. 2000).

Further, given the progressive nature of pneumoconiosis, see *Eastern Associated Coal Corporation v. Director, OWCP*, 220 F.3d 250, 258 (4<sup>th</sup> Cir. 2000), the more recent evidence with respect to the nature and extent of Claimant's pulmonary or respiratory disability would be the more probative of his condition at the time of the hearing. See *Cooley v. Island Creek Coal Co.*, 845 F.2d 622, 11 BLR 2-147 (6<sup>th</sup> Cir. 1988); see also *Wetzel v. Director, OWCP*, 8 BLR 1-139 (1985).

#### Entitlement to Benefits: In General

Entitlement to benefits depends upon proof of three elements: in general, a miner must prove that: 1) he has pneumoconiosis which 2) arose out of his coal mine employment and 3) is totally disabling. Failure to prove any of these requisite elements precludes a finding of entitlement. *Perry v. Director, OWCP*, 9 BLR 1-1 (1986)(en banc). Because Claimant has previously failed to establish any of the foregoing elements, I must review the record as a whole to determine whether he has proven that he has pneumoconiosis, 20 C.F.R. §718.202, which arose out of his coal mine employment, 20 C.F.R. §718.203, that he is totally disabled, 20 C.F.R. §718.204(c); see *Carson v. Westmoreland Coal Company*, 19 BLR 1-16 (1994), *modified on recon.* 20 BLR 1-64 (1996); see also *Beatty v. Danri Corp.*, 49 F.3d 993, 19 BLR 2-136 (3d Cir. 1995), and whether pneumoconiosis is a substantial contributor to any total pulmonary or respiratory disability. 20 C.F.R. §718.204(b); *Bonessa v. U.S. Steel Corp.*, 884 F.2d 726, 13 BLR 2-23 (3d Cir. 1989).

#### Entitlement:: Determination of Pneumoconiosis

Claimant must first establish the presence of pneumoconiosis. Pursuant to §718.202, a living miner can demonstrate pneumoconiosis by means of: (1) x-rays interpreted as being positive for the disease; or (2) biopsy evidence; or (3) the presumptions described in Sections 718.304, 718.305, or 718.306, if found to be applicable; or (4) a reasoned medical opinion which concludes presence of the disease,

if the opinion is based on objective medical evidence such as blood-gas studies, pulmonary function studies, physical exams, and medical and work histories.

The Third Circuit, under whose jurisdiction this case arose, held that all of the relevant evidence relating to pneumoconiosis under §§718.202(a)(1-4) must then be weighed together to determine whether the claimant has established the existence of pneumoconiosis by a preponderance of the evidence. *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25, 21 B.L.R. 2-104 (3<sup>rd</sup> Cir. 1997).

#### a. Chest X-ray Evidence

Chest x-ray interpretations were submitted into evidence which are relevant to the determination of whether Claimant has pneumoconiosis. The following is a listing of the admissible x-ray readings, together with the names and qualifications of the interpreting physicians<sup>4</sup>:

| Date     | Exhibit   | Doctor           | Rereading | Conclusion        |
|----------|-----------|------------------|-----------|-------------------|
| 11-14-73 | DX-29B-23 | Rhodes           | 11-14-73  | 0/0               |
| 10-31-79 | DX-29B-23 | Goui, BCR        | 10-31-79  | 0/0               |
| 10-31-79 | DX-29B-23 | Morgan, BCR,B    | 12-5-79   | 0/0               |
| 1-14-85  | DX-29     | Laucks, BCR,B    | 3-29-88   | 0/0               |
| 11-26-86 | DX-29     | Laucks, BCR,B    | 3-29-88   | 0/0               |
| 8-27-87  | DX-29B-14 | Conrad, BCR      | 8-28-87   | 1/0, p/p, 2 zones |
| 8-27-87  | DX-29B-13 | Greene, B        | 11-4-87   | 0/0               |
| 8-27-87  | DX-29B-30 | Laucks, BCR,B    | 1-3-89    | 0/0               |
| 8-27-87  | DX-29B-31 | Galgon, BCI,B    | 1-24-89   | 0/0               |
| 8-27-87  | CX-36     | Cappiello, BCR,B | 4-14-00   | ½, p/q, 6 zones   |
| 8-27-87  | CX-38     | Miller, BCR,B    | 4-26-00   | 1/1, p/p, 6 zones |
| 3-29-88  | DX-29B-25 | Laucks, BCR,B    | 3-29-88   | 0/0               |
| 5-7-92   | DX-29A-10 | Conrad, BCR      | 5-11-92   | 1/1, p/p, 2 zones |
| 5-7-92   | DX-29A-9  | Barrett, BCR,B   | 6-19-92   | 0/0               |
| 5-7-92   | DX-29A-19 | Laucks, BCR,B    | 8-18-92   | 0/0               |
| 5-7-92   | DX-29A-19 | Duncan, BCR,B    | 8-24-92   | 0/0               |
| 5-7-92   | DX-29A-19 | Robinson, BCR,B  | 8-26-92   | 0/0               |
| 5-7-92   | DX-29A-20 | Scott, BCR,B     | 9-9-92    | 0/0               |
| 5-7-92   | DX-29A-20 | Gayler, BCR,B    | 9-9-92    | 0/0               |
| 5-7-92   | DX-29A-20 | Wheeler, BCR,B   | 9-9-92    | 0/0               |

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<sup>4</sup> The symbol "BCR" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. The symbol "B" denotes a physician who was an approved "B-reader" at the time of the x-ray reading. A B-reader is a radiologist who has demonstrated his expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of Occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. §37.51 (1982).

|         |           |                  |          |                                    |
|---------|-----------|------------------|----------|------------------------------------|
| 5-7-92  | DX 29-40  | Lautin, BCR,B    | 3-22-93  | no small opacities                 |
| 5-7-92  | CX-37     | Cappiello, BCR,B | 4-14-00  | ½, p/q, 6 zones                    |
| 5-7-92  | CX-39     | Miller, BCR,B    | 4-26-00  | 1/1, p/p, 6 zones                  |
| 9-4-92  | DX-29A-21 | Laucks, BCR,B    | 9-17-92  | 0/0                                |
| 9-4-92  | DX-29A-24 | Lautin, BCR,B    | 10-28-92 | 0/0                                |
| 9-4-92  | DX-29-29  | Smith, BCR,B     | 1-21-93  | 1/1, p/s, 6 zones                  |
| 9-4-92  | DX-29-31  | Mathur, BCR,B    | 5-17-93  | 1/1, p/s, 4 zones                  |
| 9-4-92  | DX-29-33  | Marshall, BCR,B  | 5-28-93  | 2/1, s/t, 4 zones                  |
| 9-4-92  | DX-29-37  | Gayler, BCR,B    | 10-16-92 | 0/0                                |
| 9-4-92  | DX-29-36  | Scott, BCR,B     | 10-16-92 | 0/0                                |
| 9-4-92  | DX-29-35  | Wheeler, BCR,B   | 10-16-92 | 0/0                                |
| 9-4-92  | DX-29-38  | Kaplan, BCI,B    | 11-15-92 | 0/0                                |
| 9-4-92  | DX-29-39  | Sundheim, BCR,B  | 12-3-92  | no CWP, pleural thickening L chest |
| 4-8-93  | DX-29-30  | Smith, BCR,B     | 4-20-93  | 1/1, p/p, 6 zones                  |
| 4-8-93  | DX-29-31  | Mathur, BCR,B    | 5-17-93  | 1/1, p/s, 6 zones                  |
| 4-8-93  | DX-29-33  | Marshall, BCR,B  | 5-28-93  | 2/1, s/t, 6 zones                  |
| 4-8-93  | DX-29-44  | Duncan, BCR,B    | 6-28-93  | 0/0                                |
| 4-8-93  | DX-29-44  | Soble, BCR,B     | 6-30-93  | 0/0                                |
| 5-26-95 | DX-29-81  | Haber, BCR,B     | 5-26-95  | 0/0                                |
| 5-26-95 | DX-29-86  | Duncan, BCR,B    | 7-12-95  | 0/0                                |
| 5-26-95 | DX-29-86  | Laucks, BCR,B    | 7-17-95  | 0/0                                |
| 5-26-95 | DX-29-86  | Soble, BCR,B     | 7-19-95  | 0/0                                |
| 5-26-95 | DX-29-93  | Wheeler, BCR,B   | 8-24-95  | 0/0                                |
| 5-26-95 | DX-29-93  | Scott, BCR,B     | 8-24-95  | 0/0                                |
| 5-26-95 | DX-29-93  | Gayler, BCR,B    | 8-24-95  | 0/0                                |
| 5-26-95 | DX-29-92  | Lautin, BCR,B    | 9-21-95  | 0/0                                |
| 7-22-97 | DX-28     | Scott, BCR,B     | 11-20-97 | 0/0                                |
| 7-22-97 | DX-28     | Gaylor, BCR,B    | 11-20-97 | 0/0                                |
| 7-22-97 | DX-28     | Wheeler, BCR,B   | 11-21-97 | 0/0                                |
| 7-30-97 | DX-11&13  | Ciotola, BCR,B   | 7-30-97  | 0/0                                |
| 7-30-97 | DX-11&14  | Barrett, BCR,B   | 8-14-97  | 0/0                                |
| 7-30-97 | DX-24&39  | Duncan, BCR,B    | 11-13-97 | 0/0                                |
| 7-30-97 | DX-24&39  | Laucks, BCR,B    | 11-20-97 | 0/0                                |
| 7-30-97 | DX-24&39  | Soble, BCR,B     | 11-24-97 | 0/0                                |
| 7-30-97 | DX-37     | Lautin, BCR,B    | 2-17-98  | 0/0                                |
| 7-30-97 | DX-42     | Mathur, BCR,B    | 7-1-98   | 1/1, p/s, 6 zones                  |
| 7-30-97 | DX-45     | Smith, BCR,B     | 7-13-98  | 1/1, p/s, 6 zones                  |
| 7-30-97 | DX-42     | Mathur, BCR,B    | 7-1-98   | 1/1, p/s, 6 zones                  |
| 7-30-97 | CX-8      | Brandon, BCR,B   | 7-20-98  | 1/1, s/p, 6 zones                  |
| 11-7-97 | DX-22&23  | Ciotola, BCR,B   | 11-7-97  | 0/0                                |
| 11-7-97 | DX-27     | Gaylor, BCR,B    | 1-16-98  | 0/0                                |
| 11-7-97 | DX-27     | Scott, BCR,B     | 1-16-98  | 0/0                                |
| 11-7-97 | DX-27     | Wheeler, BCR,B   | 1-17-98  | 0/0                                |
| 11-7-97 | DX-38     | Lautin, BCR,B    | 2-7-98   | 0/0                                |
| 11-7-97 | DX-41     | Mathur, BCR,B    | 6-4-98   | 1/1, p/s, 6 zones                  |

|         |          |                  |          |                   |
|---------|----------|------------------|----------|-------------------|
| 11-7-97 | DX-43&44 | Pathak, B        | 6-10-98  | 1/1, p/q, 6 zones |
| 11-7-97 | DX-43&44 | Miller, BCR,B    | 6-12-98  | 1/1, p/q, 6 zones |
| 11-7-97 | DX-43&44 | Aycoth, B        | 6-18-98  | 1/0, p/p, 6 zones |
| 11-7-97 | DX-43&44 | Ahmed, BCR,B     | 6-22-98  | 1/1, p/q, 6 zones |
| 11-7-97 | DX-43&44 | Cappiello, BCR,B | 6-23-98  | 1/1, p/q, 6 zones |
| 11-7-97 | DX-45    | Smith, BCR,B     | 7-13-98  | 1/1, p/s, 6 zones |
| 11-7-97 | CX-7     | Brandon, BCR,B   | 7-20-98  | 1/1, s/p, 6 zones |
| 8-20-99 | EX-4     | Wheeler, BCR,B   | 10-6-99  | 0/0               |
| 8-20-99 | EX-4     | Scott, BCR,B     | 10-11-99 | 0/0               |
| 8-20-99 | CX-22    | Cappiello, BCR,B | 12-17-99 | ½, p/q, 6 zones   |
| 8-20-99 | CX-29    | Mathur, BCR,B    | 1-29-00  | 1/1, p/s, 6 zones |

Where two or more x-ray reports are in conflict, the radiologic qualifications of the physicians interpreting the x-rays must be considered. §718.202(a)(1). The interpretations of dually qualified physicians are entitled to more weight than the interpretations of B-readers. *Herald v. Director, OWCP*, BRB No. 94-2354 BLA (Mar. 23, 1995)(*unpublished*). It is also proper to accord more weight to the more recent x-ray films of record. *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-49 (1989) (en banc).

There are seventy-six (76) interpretations of thirteen (13) x-rays in the record. Of the seventy-six (76) interpretations, fifty (50) were negative and twenty-six (26) were positive for pneumoconiosis. There are forty-five (45) negative interpretations that have been rendered by Board-Certified Radiologists and B-readers. Whereas there are twenty-two (22) positive interpretations rendered by dually qualified physicians. The record contains four (4) interpretations of the most recent x-ray, from 8-20-99. Of the four (4), there are two (2) positive interpretations by dually qualified physicians and two (2) negative interpretations by dually qualified physicians.

I accord more weight to the interpretations of the dually qualified Board-certified radiologists and B-readers. As noted earlier, Employer objected to Claimant's submission of new x-ray readings of old x-rays (CX-7, 8, 36 through 39). All of these interpretations were rendered by dually qualified physicians. At the hearing, I noted 20 C.F.R. §725.456 restrains parties from going back and redoing old evidence. Nevertheless, I agreed to allow the documents to remain for appellate review while noting a concern about their probative value. Overall, the number of negative interpretations (45) by dually qualified physicians overwhelmingly exceed the positive interpretations (22). If I were to exclude the objectionable readings submitted by Claimant, the number of positive interpretations by dually qualified physicians would be reduced to sixteen (16). In either scenario, the negative interpretations far outweigh the positive interpretations.

However, the most recent x-ray evidence is evenly divided between the Claimant and Employer (i.e. 2 positive interpretations and 2 negative interpretations by dually qualified physicians). In *Director, OWCP v. Greenwich Collieries*, 114 S.Ct. 2251 (1994), *aff'g. sub. nom., Greenwich Collieries v. Director, OWCP*, 990 F.2d 730 (3d Cir.

1993), the United States Supreme Court dispensed with the “true doubt” rule thereby requiring claimants to establish the requisite elements of entitlement by a preponderance of the evidence. Accordingly, since the most recent evidence is evenly divided between the Claimant and Employer, I find that Claimant has failed to prove by the preponderance of the evidence the existence of pneumoconiosis by x-ray evidence.

b. Biopsy Evidence

Pursuant to §718.202(a)(2) Claimant may establish pneumoconiosis through the use of biopsy evidence. Since no such evidence was submitted, it is clear that pneumoconiosis has not been established in this manner.

c. The Presumptions

Under §718.202(a)(3) it shall be presumed that a miner is suffering from pneumoconiosis if the presumptions provided in §§718.304, 718.305, or 718.306 apply.

Initially, I note that Claimant cannot qualify for the §718.305 presumption because he did not file this claim before January 1, 1982. Claimant is also ineligible for the §718.306 presumption because he is still living. Moreover Claimant is ineligible for the §718.304 presumption as there is no evidence that Claimant suffers from complicated pneumoconiosis.

Based on the foregoing, it is clear Claimant has failed to establish the existence of pneumoconiosis pursuant to §718.202(a)(3).

d. Medical Opinions

Lastly, under §718.202(a)(4) a finding of pneumoconiosis may be based on the opinion of a physician, exercising sound medical judgment, who concludes that the Miner suffers or suffered from pneumoconiosis. Such conclusion must be based on objective medical evidence and must be supported by a reasoned medical opinion. Of record are the opinions of Drs. Evans, Cable, Dittman, Ahluwalia, Dirnberger, Kraynak, Corazza, Kruk, Nuschke, and Hertz.

Dr. Evans, whose qualifications are not of record, examined Claimant on November 8, 1979. DX-29B-26. He noted Claimant complained of cough, occasional wheezing and dyspnea. He reported a smoking history of one and one half packs a day for fifteen years. Diagnostic studies included a chest x-ray that was read as negative, arterial blood gas studies, and a pulmonary function study. Dr. Evans diagnosed Claimant as having chronic obstructive pulmonary disease (COPD) and pulmonary fibrosis related to coal mine dust exposure based on Claimant’s employment history and vent studies. Dr. Evans offered no opinion on the issue of disability.

Dr. Joseph Cable, whose qualifications are not of record, examined Claimant on August 27, 1987. DX-29B-11. Dr. Cable obtained a chest x-ray, pulmonary function

study, arterial blood gases, an exercise test and an EKG. He noted a twenty pack year smoking history ending in 1965. Dr. Cable diagnosed Claimant as having COPD, hypertension, pleural thickening of unknown etiology and possible beta blocking produced bronchospasm. He added Claimant's chest x-ray did not support a finding of pneumoconiosis and that Claimant's respiratory condition was not related to coal dust exposure. Dr. Cable did not comment on the issue of disability.

Dr. T.H. Dittman, who is Board-Certified in Internal Medicine, examined Claimant on March 29, 1988. He obtained a chest x-ray, pulmonary function study, arterial blood gases, an exercise test and an EKG. Dr. Dittman added that Claimant had smoked a pack of cigarettes per day for sixteen (16) years. He stated that Claimant's x-ray was read by a Board-certified radiologist and B-reader as negative. He added that his vent study showed no obstructive or restrictive defect and that Claimant's blood gases were normal. Dr. Dittman opined Claimant did not have pneumoconiosis and that Claimant was not physically impaired or disabled due to pneumoconiosis.

Dr. Dittman reiterated his conclusions and findings at a deposition on March 10, 1989. DX-29B-32.

Dr. N.H. Ahluwalia, whose credentials are not part of the record, examined Claimant on May 7, 1992. DX-29A-7. Dr. Ahluwalia obtained a chest x-ray, pulmonary function study, arterial blood gases, an exercise test and an EKG. He noted a 16 pack year smoking history ending in 1966 or 1967. He diagnosed Claimant as having pleural thickening and COPD due to cigarette smoking. He opined Claimant had a mild impairment but not sufficient to prevent him from performing his last coal mine employment.

Dr. Dittman examined Claimant again on September 4, 1992. DX-29A-23. He obtained the same battery of tests that showed no restrictive or obstructive defect. Claimant's chest x-rays of 9-4-92 and 3-29-88 were read as negative by Dr. Laucks, a Board-certified radiologist and B-reader. Dr. Dittman concluded Claimant did not have pneumoconiosis and that he was not physically impaired or disabled due to pneumoconiosis.

Dr. Thomas Dirnberger, who is Board-Certified in Family Practice, submitted a medical note dated February 12, 1993 indicating that Claimant was being treated at his office. DX-29-29. He noted that chest x-rays taken on 5-11-92 and 1-21-93 were read as positive for pneumoconiosis. Dr. Dirnberger opined that Claimant had a form of restrictive lung disease compatible with pneumoconiosis due to dyspnea at rest and with exercise. He noted further that Claimant was totally and permanently disabled by this condition.

Dr. Raymond Kraynak, who is Board-Eligible in Family Medicine, submitted a medical report dated May 5, 1993. DX-29-30. He stated that Claimant had been under his care since April 8, 1993. Dr. Kraynak obtained a pulmonary function study and a chest x-ray that had been read by Dr. Smith as positive for pneumoconiosis. Physical

examination revealed slightly cyanotic lips and a mild increase in Claimant's AP diameter. Based on Claimant's history of 20 years of coal mine employment, his complaints, diagnostic tests, and his physical examination, Dr. Kraynak opined Claimant was totally and permanently disabled due to pneumoconiosis.

The deposition of Dr. Dittman was taken on May 10, 1993. DX-29-43. Dr. Dittman reiterated his opinion that Claimant did not have pneumoconiosis and Claimant was not totally disabled by pneumoconiosis.

In a medical note dated March 7, 1995, Dr. Kraynak advised that he was still Claimant's treating physician and that Claimant had a worsening of conditions as of his January 31, 1995 evaluation. DX-29-76.

Dr. Dittman examined Claimant again on June 20, 1995. DX-29-82. Based upon his examination that included arterial blood gas studies and pulmonary function studies, Dr. Dittman concluded Claimant had hypertension, s/p bunionectomy, possible tophaceous gout, history of herniated intervertebral disc, history of peptic ulcer disease, history of nephrolithiasis, s/p appendectomy, fracture of left leg, and bilateral olecranon bursitis. Dr. Dittman opined that Claimant did not have pneumoconiosis and was not physically impaired or disabled on the basis of coal worker's pneumoconiosis.

Dr. Leo J. Corazza, who is Board-Certified in Internal Medicine, examined Claimant on September 2, 1997. DX-11. He noted a smoking history of one pack per day from age nineteen (19) to forty-three (43). Based on the results of pulmonary function studies, arterial blood gases and a chest x-ray, Dr. Corazza concluded Claimant had pleural thickening, restrictive pulmonary disease and hypertension. He opined the restrictive pulmonary disease was caused primarily by musculoskeletal changes secondary to arthritis. The pleural thickening could contribute to this as well. The etiology of the pleural thickening was unclear to Dr. Corazza. He concluded that Claimant's pulmonary condition would preclude employment in the coal mines.

Dr. Dittman examined Claimant again on November 7, 1997. DX-23. He conducted arterial blood gases and pulmonary function studies and found that Claimant did not have pneumoconiosis and he was disabled on the basis of that disease. He reviewed the report of Dr. Corazza before rendering his opinion.

The deposition of Dr. Raymond Kraynak was taken on June 26, 1998. DX-43. He noted a smoking history of a half a pack per day for fifteen (15) years ending thirty-five (35) years ago. He reiterated his opinion that Claimant suffered from pneumoconiosis and that he was totally disabled by said disease. Dr. Kraynak disagreed with the opinions of Drs. Dittman and Corazza.

In a letter dated April 5, 1999, Dr. Raymond Kraynak opined Claimant's condition had worsened and that he was totally and permanently disabled due to coal worker's pneumoconiosis. DX-53.

Dr. Dittman examined the Claimant on August 20, 1999. EX-3. At that time he noted an extensive occupational history and stated that Claimant last worked as an electrician repairing motors and machinery in the coal mines. Claimant stopped working on December 30, 1986 due to his respiratory problem. Claimant reported a medical history of appendectomy in 1940, bunionectomy in 1995, left leg fracture in 1927, peptic ulcer disease 1960s, nephrolithiasis 1970s, herniated intervertebral disc in 1980s, and hypertension for twenty (20) to twenty-five (25) years. Dr. Dittman noted a smoking history of one pack of cigarettes per day for 18 years having stopped at age 45. Current medications included Corgard, hydrochlorothiazide, Allopurinol, Indocin (for gout) and an inhaler. Claimant's current symptoms included shortness of breath, dyspnea on exertion when walking half (½) a block or up six (6) to seven (7) steps, cough with sputum production, nocturnal wheezing, and two (2) pillow orthopnea. Physical examination was unremarkable. A chest x-ray read by Dr. Ciotola showed no parenchymal evidence of pneumoconiosis, a ventilation study showed mild obstructive defect (but with less than maximal effort), arterial blood gases were normal, and an EKG showed normal sinus rhythm. Dr. Dittman diagnosed Claimant as having hypertension (not under adequate control), tophaceous gout, and atherosclerotic vascular disease. Based on Claimant's normal physical examination, arterial blood gases, negative x-ray, and a vent study with inconsistent effort demonstrating a mild obstructive defect at worst, Dr. Dittman concluded Claimant does not have pneumoconiosis. He also opined Claimant was not disabled due to coal worker's pneumoconiosis.

Dr. Stephen M. Kruk, who is Board-Certified in Internal Medicine (CX-5), submitted a medical report dated October 13, 1999. CX-4. He noted that he initially evaluated Claimant in April of 1998 at which time he diagnosed Claimant as having pneumoconiosis. Currently, Claimant stated that "little has changed since his previous evaluation in April of 1998." Claimant reported that his breathing is slowly getting worse and his exercise tolerance is less as he becomes extremely dyspneic with minimal exertion. Physical examination was unremarkable. Dr. Kruk concluded that Claimant was totally and permanently disabled secondary to pneumoconiosis. He added that Claimant's breathing, as expected, seemed to be worsening with age. He also considered Claimant's pneumoconiosis to be the cause of his severe dyspnea with minimum exertion.

Dr. John D. Nuschke, Jr., who is Board-Certified in Internal Medicine and Geriatric Medicine (CX-33), submitted a medical report dated December 22, 1999. CX-32. He noted that he had been Claimant's treating physician since 1989. He added that he sees Claimant two (2) to three (3) times per year for treatment of chronic medical problems which include hypertension, gout, osteoarthritis, remote history of peptic ulcer, and history of pneumoconiosis related to 22 years of coal mine employment. Dr. Nuschke added that radiographic findings were consistent with previous anthracite exposure. He stated that pulmonary function studies in 1995 showed a mild obstructive pattern. He noted Claimant's complaints of significant dyspnea on exertion. Dr. Nuschke opined Claimant's pneumoconiosis would be a substantial contributing factor to his inability to return to last coal mine employment.

Dr. Dittman testified at a deposition on January 14, 2000. EX-15. He noted that a smoking history of 18 pack years was significant. He concluded that Claimant is not suffering from any coal mine dust related pulmonary condition.. It was his opinion Claimant could return to his last coal mine employment from a pulmonary standpoint. He noted that there was no significant worsening of Claimant's condition since his examination in 1998. He stated that if COPD were present he would attribute the condition to smoking. Dr. Dittman concluded that Claimant does not suffer from any disabling industrial bronchitis.

Dr. Dittman submitted a supplemental report dated March 22, 2000. EX-9. He indicated he had reviewed medical records of Dr. Nuschke from 8-4-89 to 12-20-99. He concluded that based on these records, Claimant has not had any significant cardiopulmonary complaints over the years. There is very rare mention of Claimant having dyspnea and there is no mention of any treatment for lung disease. Dr. Dittman noted that there was some mention of an interstitial lung disease as well as pneumoconiosis and COPD, but there was no therapy rendered. He added that the x-rays in Dr. Nuschke records did not indicate the presence of pneumoconiosis and vent studies showed a mild obstructive defect. Dr. Dittman concluded that these records further substantiated his view that Claimant did not have any physically impairing or disabling lung disease of any type.

Dr. Matthew Kraynak, who is Board-Certified in Family Medicine, submitted a medical report dated April 14, 2000. CX-41. He noted that he was treating Claimant for shortness of breath with minimal exertion. Based on pulmonary function studies performed on 1-4-00, various x-rays that were all read as positive for pneumoconiosis, twenty-two (22) years of coal mine employment, Claimant's complaints, and physical examination that showed cyanosis of the lips and scattered wheezes, Dr. Kraynak concluded Claimant was totally and permanently disabled due to pneumoconiosis contracted during his employment in the anthracite coal mine industry.

Dr. Raymond Kraynak testified at a deposition on April 28, 2000. CX-35. He noted that he still sees Claimant every two months for complaints of shortness of breath when walking less than one and a half blocks or up several steps and productive cough. He added that on physical examination, Claimant looked older than stated age, had intermittent cyanotic lips, and scattered wheezes in the lungs. He concluded Claimant had coal worker's pneumoconiosis due to employment in the coal mine industry and was totally and permanently disabled due to CWP. Dr. Kraynak added that Claimant has other medical conditions that are disabling, i.e. high blood pressure, gout, arthritis, remote peptic ulcer. Dr. Kraynak added that Claimant's respiratory condition had worsened over the time he has cared for him. Dr. Kraynak acknowledged that the majority of examinations since 1998 have produced similar findings but insisted that Claimant's complaints of exertional dyspnea have gotten worse. He acknowledged that the values obtained in pulmonary function studies performed by Dr. Matthew Kraynak and Dr. Dittman in January of 2000 are higher than those values obtained in 3-99, 8-99 and 10-99.

Dr. Jonathan Hertz, who is Board-Certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine, submitted a medical records review dated May 16, 2000. EX-13. Dr. Hertz opined that Claimant did not have pneumoconiosis and was not disabled by the disease. He commented that he was impressed with the records of Dr. Nuschke that dated back ten (10) years. He added that although there was mention of a potential interstitial lung disease and COPD on some reports, it was clear Dr. Nuschke did not use standard therapy for lung disease or pneumoconiosis. Dr. Nuschke made little reference to any deteriorating pulmonary status. Dr. Hertz added that Claimant was on Corgard, a beta-blocker, to treat high blood pressure. However, this drug would be contraindicated in a patient with a significant or severe lung disease such as pneumoconiosis. Dr. Hertz noted that the fact that Dr. Nuschke felt free to use a beta-blocker suggested a lack of concern for a significant underlying pulmonary condition. Dr. Hertz noted that pulmonary function studies performed in Dr. Nuschke office were essentially normal. Whereas vent studies performed in Dr. Kraynak's office four (4) years later demonstrate a significant decline in values. Dr. Hertz opined it would be exceedingly unusual for pulmonary function to deteriorate so rapidly over four years, particularly since Claimant had retired from coal mining. The dramatic change in vent values from 1995 to 1999 demonstrated to him a sub-optimal effort and excessive variation.

Out of the eleven (11) physicians who have rendered an opinion in this matter, Drs. Cable, Dittman, Ahluwalia, Corazza and Hertz conclude Claimant does not suffer from pneumoconiosis. Whereas, Drs. Evans, Dirnberger, Raymond Kraynak, Kruk, Nuschke, and Matthew Kraynak conclude Claimant does suffer from pneumoconiosis.

After a review of the medical records, I accord more weight to the opinions of Drs. Dittman and Hertz. Dr. Dittman is a highly qualified physician who is Board-Certified in Internal Medicine and Board eligible in pulmonary medicine. He has examined the Claimant on at least five (5) occasions since 1988. His medical reports are well-reasoned, well-documented and are supported by the objective diagnostic testing of record. His conclusions are supported by the detailed medical record review that was conducted by Dr. Hertz, who is Board-Certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine. Dr. Hertz pointed out that Claimant's treating physician, Dr. Nuschke, made little reference to a pulmonary disease over the course of ten (10) years and had prescribed a beta-blocker to treat Claimant's high blood pressure. He noted that this drug would be contraindicated in a patient with significant or severe lung disease such as pneumoconiosis thereby indicating a lack of concern on the part of Dr. Nuschke for a significant underlying pulmonary condition. Moreover, the earlier opinions of Drs. Cable, Ahluwalia, and Corazza are well-reasoned and are corroborated by the subsequent findings of Drs. Dittman and Hertz.

I accord less weight to the opinions of Drs. Evans, Dirnberger, Raymond Kraynak, Kruk, Nuschke, and Matthew Kraynak. Their reports are not sufficient to establish that Claimant is suffering from pneumoconiosis. Their opinions are contrary to the x-ray evidence as well as the credible pulmonary function and blood gas testing. The opinion of Dr. Nuschke is effectively undermined by the report of Dr. Hertz as

discussed above. It is unclear in the medical report of Dr. Kruk if he reviewed any B-readings of any chest x-rays, pulmonary function studies, or arterial blood gases in reaching his conclusion that Claimant suffered from pneumoconiosis. Likewise, Dr. Dirnberger provided no reasoned medical basis for his judgment that Claimant suffered from pneumoconiosis. Dr. Evans conclusion of COPD and pulmonary fibrosis was based, in part, on pulmonary function studies that were subsequently invalidated. For these reasons, these opinions are accorded less weight.

The medical opinions of Drs. Raymond and Matthew Kraynak cannot be accorded significant weight. Drs. Kraynak base their diagnoses of pneumoconiosis, in part, on positive x-ray readings without consideration of the vast majority of negative B-readings in the record. Drs. Kraynak also base their diagnoses, in part, on pulmonary function studies that are subsequently invalidated by consulting physicians. Moreover, it has been pointed out that effort-dependent pulmonary function studies performed by Dr. Raymond Kraynak consistently produced significantly lower values than those performed by other physicians. In fact the values produced in vent studies by Dr. Matthew Kraynak and Dr. Dittman in January of 2000 yielded higher results than those obtained by Dr. Raymond Kraynak in 3-99, 8-99 and 10-99.

Based on the foregoing, I conclude that Claimant has failed to establish the existence of pneumoconiosis by the preponderance of the evidence pursuant to §718.202(a)(4).

e. The Existence of Pneumoconiosis Pursuant to 20 C.F.R. 718.202(a)

I must now weigh all the relevant evidence under 718.202(a) in determining whether Claimant has established the existence of pneumoconiosis. *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3d Cir. 1997).

As noted previously, I found that the preponderance of the evidence in the record does not establish the existence of pneumoconiosis pursuant to 718.202(a)(1) – (3). There were no autopsy or biopsy results in the record pursuant to 718.202(a)(2). In addition, none of the presumptions contained within 718.202(a)(3) were found to be applicable. Accordingly, the Claimant's chest x-rays pursuant to 718.202(a)(1) and the medical reports pursuant to 718.202(a)(4) are considered relevant evidence in making this determination.

After careful evaluation of the evidence, I found in this opinion that Claimant failed to prove, by the preponderance of the evidence, the existence of pneumoconiosis pursuant to §718.202(a)(1) that allows for the establishment of pneumoconiosis by chest x-ray. He also failed to establish pneumoconiosis pursuant to §718.202(a)(4) that allows for the establishment of pneumoconiosis through the well-reasoned medical report of a physician.

I further find, in weighing all of the relevant evidence together, that Claimant failed to establish the existence of pneumoconiosis by a preponderance of the evidence

pursuant to 718.202(a). The well-reasoned opinions of Drs. Dittman, Hertz, Cable, Ahluwalia and Corazza, supported by the overwhelming majority of negative B-readings in evidence outweigh the reports of Drs. Evans, Dirnberger, Raymond Kraynak, Kruk, Nuschke and Matthew Kraynak.<sup>5</sup> Therefore, the Claimant has failed to establish by the preponderance of the evidence that he suffers from pneumoconiosis pursuant to 718.202(a).

#### Cause of Pneumoconiosis Pursuant to 718.203

Once it is determined that the miner suffers from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. 718.203(a).

If Claimant had established the existence of pneumoconiosis, Employer indicated in his closing brief that they would concede that pneumoconiosis was due to Claimant's coal dust exposure. However, since Claimant was unable to establish the existence of pneumoconiosis, this element is moot.

#### Total Disability Due to Pneumoconiosis Pursuant to 718.204(b)

The finding of the existence of a totally disabling respiratory or pulmonary impairment shall be made under the provisions of Section 718.204. In making this determination, I must evaluate all relevant evidence. *See Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987). A claimant shall be considered totally disabled if he is prevented from performing his usual coal mine work or comparable and gainful work. In the absence of contrary probative evidence, evidence which meets one of the Section 718.204(c) standards shall establish claimant's total disability. *See Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195 (1986).

According to §718.204(c), the criteria to be applied in determining total disability include: 1) pulmonary function studies, 2) arterial blood gas test, 3) a diagnosis of cor pulmonale with right-sided congestive heart failure, and 4) a reasoned medical opinion concluding total pulmonary or respiratory disability. I must also consider claimant's testimony in all of the hearings to compare the medical opinion disability assessments against that testimony regarding the physical requirements of his usual coal mine work. *See generally Onderko v. Director, OWCP*, 14 BLR 1-2 (1988).

#### Pulmonary Function Studies

In order to demonstrate total respiratory disability on the basis of pulmonary function study evidence, a claimant may provide studies, which, accounting for sex, age, and height, produce a qualifying value for the FEV 1 test, plus either a qualifying value for the FVC test, or the MVV test, or a value of the FEV 1 divided by the FVC less than or equal to 55 percent. "Qualifying values" for the FEV 1, FVC and the MVV test

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<sup>5</sup> see discussion above

are measured results less than or equal to the values listed in the appropriate tables of Appendix B to 20 C.F.R. Part 718. See *Director, OWCP v. Siwiec*, 894 F.2d 635, 637 n.5, 13 BLR 2-259 (3d Cir. 1990).

Assessment of the pulmonary function study results is dependent on the Claimant's height, which has been recorded between 68 and 70 inches. Considering this discrepancy, I find that Claimant's height is 69.05 inches for purposes of evaluating the pulmonary function studies. See *Protopappas v. Director, OWCP*, 6 BLR 1-221 (1983).

The Secretary's regulations allow for the review of pulmonary function testing by experts who can review the ventilatory tracings and determine the validity of a particular test. 20 C.F.R. §718.103 and Part 718, Appendix B; *Siwiec, supra*; see generally *Ziegler Coal Co. v. Sieberg*, 839 F.2d 1280, 1283, 11 BLR 2-80 (7<sup>th</sup> Cir. 1988). Thus, in assessing the probative value of a clinical study, an administrative law judge must address "valid contentions" raised by consultants who review such tests. See *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276, 18 BLR 2-42 (7<sup>th</sup> Cir. 1993); *Dotson v. Peabody Coal Co.*, 846 F.2d 1134, 1137-38 (7<sup>th</sup> Cir. 1988); *Strako v. Ziegler Coal Co.*, 3 BLR 1-136 (1981); also see *Siegel v. Director, OWCP*, 8 BLR 1-156 (1985)(2-1 opinion with Brown, J., dissenting); accord *Winchester v. Director, OWCP*, 9 BLR 1-177 (1986).

The Third Circuit has emphasized that the administrative law judge "must determine whether the tests meet the quality standards and whether the medical evidence is reliable[.]" *Siwiec*, 894 F.2d at 638, 13 BLR 2-259.

The record includes the following pulmonary function study evidence:

| Ex. No.   | Date     | Age | Ht. | FEV1 | FVC  | MVV | FEV1/FVC | Qualify |
|-----------|----------|-----|-----|------|------|-----|----------|---------|
| DX-29B-23 | 10-26-73 | 50  | 70" | 2.90 | 4.20 | 77  | 69%      | No      |

Dr. Steele interpreted this test as a normal study. Claimant's performance was listed as "cooperative." This test is in substantial compliance with the regulations.

| Ex. No.   | Date     | Age | Ht. | FEV1 | FVC  | MVV | FEV1/FVC | Qualify |
|-----------|----------|-----|-----|------|------|-----|----------|---------|
| DX-29B-23 | 10-31-79 | 56  | 70" | 1.74 | 3.24 | 57  | 53%      | Yes     |

This test was performed at the direction of Dr. Evans. Claimant's cooperation was noted as "fair" and his comprehension was noted as "good." This study was subsequently reviewed by Dr. McQuillan who stated that the vents were unacceptable due to improper performance of the study. He noted "Unacceptable FEV per speed."

I will credit Dr. McQuillan's unanswered invalidation of this study.

| Ex. No.   | Date    | Age | Ht. | FEV1 | FVC  | MVV  | FEV1/FVC | Qualify |
|-----------|---------|-----|-----|------|------|------|----------|---------|
| DX-29B-23 | 8-26-80 | 56  | 70" | 2.03 | 2.33 | 36.9 | 87%      | Yes     |

This test was performed at the direction of Dr. Evans. Claimant's cooperation and comprehension was noted as "good." These results were subsequently reviewed by Dr. McQuillan who validated the study.

I will credit Dr. McQuillan's unanswered validation of this study and find this test in substantial compliance with the regulations.

| Ex. No.   | Date    | Age | Ht. | FEV1 | FVC  | MVV | FEV1/FVC | Qualify |
|-----------|---------|-----|-----|------|------|-----|----------|---------|
| DX-29B-10 | 8-27-87 | 63  | 70" | 2.69 | 3.67 | 81  | 73%      | No      |

Dr. Cable interpreted this test as showing a mild obstructive disease. Claimant's cooperation and comprehension were noted as "good." This test is in substantial compliance with the regulations.

| Ex. No.   | Date    | Age | Ht. | FEV1  | FVC   | MVV  | FEV1/FVC | Qualify |
|-----------|---------|-----|-----|-------|-------|------|----------|---------|
| DX-29B-26 | 3-29-88 | 64  | 69" | 2.34  | 3.11  | 92   | 75%      | No      |
|           |         |     |     | *2.55 | *3.33 | *116 | 77%      | No      |

Dr. Dittman interpreted this test as showing no evidence of a restrictive vent defect and no evidence of an obstructive vent defect. Claimant's cooperation and comprehension was noted as "good." This test is in substantial compliance with the regulations.

| Ex. No.  | Date   | Age | Ht. | FEV1 | FVC  | MVV | FEV1/FVC | Qualify |
|----------|--------|-----|-----|------|------|-----|----------|---------|
| DX-29A-6 | 5-7-92 | 68  | 68" | 2.13 | 2.90 | 45  | 73%      | No      |

Dr. Ahluwalia interpreted this test as showing a mild airflow limitation. Claimant's cooperation was noted as "fair while his comprehension was noted as "good." This test is in substantial compliance with the regulations.

| Ex. No.   | Date   | Age | Ht. | FEV1  | FVC   | MVV | FEV1/FVC | Qualify |
|-----------|--------|-----|-----|-------|-------|-----|----------|---------|
| DX-29A-23 | 9-4-92 | 68  | 69" | 2.56  | 3.32  | 67  | 77%      | No      |
|           |        |     |     | *2.42 | *3.30 | *69 | 73%      | No      |

Dr. Dittman interpreted this test as showing no evidence of a restrictive vent defect and no evidence of an obstructive vent defect. Claimant's cooperation and comprehension was noted as "good." This test is in substantial compliance with the regulations.

| Ex. No.  | Date    | Age | Ht. | FEV1 | FVC  | MVV | FEV1/FVC | Qualify |
|----------|---------|-----|-----|------|------|-----|----------|---------|
| DX-29-32 | 5-18-93 | 69  | 68" | 1.42 | 1.56 | 34  | 91%      | Yes     |

This test was performed at the William H. Ressler Center at the request of Dr. Raymond Kraynak. Claimant's cooperation and comprehension were noted as "good." Dr. Levinson, who is Board-Certified in Internal Medicine and Pulmonary Disease,

invalidated the study indicating the effort expended by Claimant was unacceptable. There was excessive variability of the FEV-1s indicating Claimant had not expended maximal effort. The curves varied by 350 mls, greatly exceeding that allowed by regulations. In addition the MVV curves indicated a poor and inconsistent effort so that Claimant had not maintained a maximal sustained effort for 12 to 15 seconds as required. DX-29.

Dr. Kraynak, who is Board-Eligible in Family Medicine, responded to the invalidation by disagreeing with Dr. Levinson and maintained that the study was valid.

I have considered Dr. Kraynak's dispute with the conclusions reached by Dr. Levinson. Nevertheless, I credit the invalidation opinion of Dr. Levinson on the basis of his credentials. He is Board-Certified in Internal Medicine and Pulmonary Disease. Moreover, Dr. Levinson is the Director of Respiratory Disease and Respiratory Care Services as well as the Director of the pulmonary function laboratory at both Mercy Hospital and Moses Taylor Hospital in Scranton, Pennsylvania. He also is Director of the Coal Workers' Respiratory Disease Clinic. See *Martinez v. Clayton Coal Co.*, 10 BLR 1-24 (1987); *Dillon v. Peabody Coal Co.*, 11 BLR 1-113 (1988); *Wetzel v. Director, OWCP*, 8 BLR 1-139 (1985); see generally *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989)(en banc).

| Ex. No.  | Date    | Age | Ht. | FEV1 | FVC  | MVV | FEV1/FVC | Qualify |
|----------|---------|-----|-----|------|------|-----|----------|---------|
| DX-29-73 | 1-31-95 | 71  | 69" | 1.72 | 2.40 | 61  | 72%      | Yes     |

Dr. Kraynak interpreted this test as showing a severe restrictive defect. Claimant's cooperation and comprehension were noted as "good." This test was subsequently invalidated by Drs. Sahillioglu, Levinson, and Kaplan. Dr. Levinson noted the entire FVC curves had not been displayed and that the starting point of exhalation began before the point marked as the zero point. Moreover he opined the FEV-1 and FVC did not reflect the true and complete capacities of Claimant. In addition, the MVV curves indicated a poor and inconsistent effort so that Claimant had not maintained a maximal sustained effort for 12 to 15 seconds as required. DX-29-79. Dr. Sahillioglu noted that the vents were not acceptable due to inconsistent effort. He also noted an absence of an inspiratory effort. Dr. Sahillioglu added that a restrictive defect needed to be verified by TLC determination. DX-29-73. Dr. Robin Kaplan invalidated this study as there was no documentation that the spirometer was properly calibrated before the test. Moreover, close inspection of the individual curves showed subtle variations in air flow that strongly suggested Claimant's efforts were not maximal. DX-29-80.

I will credit the unanswered invalidations of this study by Drs. Levinson, Sahillioglu and Kaplan and find this test is not in substantial compliance with the regulations.

| Ex. No.  | Date    | Age | Ht. | FEV1  | FVC   | MVV   | FEV1/FVC | Qualify |
|----------|---------|-----|-----|-------|-------|-------|----------|---------|
| DX-29-82 | 5-26-95 | 71  | 69" | 2.33  | 3.07  | 75.7  | 76%      | No      |
|          |         |     |     | *2.55 | *3.45 | *85.5 | 74%      | No      |

Dr. Dittman interpreted this test as showing no evidence of a restrictive vent defect and mild, early obstructive vent defect with no significant change after bronchodilator. Claimant was noted to be cooperative. This test is in substantial compliance with the regulations.

| Ex. No. | Date   | Age | Ht. | FEV1 | FVC  | MVV | FEV1/FVC | Qualify |
|---------|--------|-----|-----|------|------|-----|----------|---------|
| DX-10   | 9-2-97 | 74  | 69" | 2.08 | 2.63 | 69  | 79%      | No      |

Dr. Corazza interpreted this test as showing no evidence of air trapping on the tracing. The tracing was compatible with the diagnosis of some restrictive pulmonary disease. Claimant's cooperation and comprehension were noted as "good." This test is in substantial compliance with the regulations.

| Ex. No. | Date    | Age | Ht. | FEV1  | FVC   | MVV | FEV1/FVC | Qualify |
|---------|---------|-----|-----|-------|-------|-----|----------|---------|
| DX-23   | 11-7-97 | 74  | 69" | 1.82  | 2.45  | 83  | 74%      | No      |
|         |         |     |     | *2.02 | *2.53 | *70 | 80%      | No      |

Dr. Dittman interpreted this test as showing a mild obstructive defect with no significant improvement after bronchodilators. He also noted a possible co-existing borderline restrictive defect. Claimant's cooperation and comprehension was noted as "good." This test is in substantial compliance with the regulations.

| Ex. No.  | Date    | Age | Ht. | FEV1 | FVC  | MVV | FEV1/FVC | Qualify |
|----------|---------|-----|-----|------|------|-----|----------|---------|
| DX-36&43 | 6-25-98 | 74  | 69" | 1.89 | 2.72 | 42  | 69%      | No      |

Dr. Kraynak interpreted this test as showing a severe restrictive defect. Claimant's cooperation and comprehension were noted as "good." This test was

subsequently invalidated by Drs. Levinson and Kaplan.<sup>6</sup> Dr. Levinson stated that the study was not valid because it had been improperly performed. He opined the FEV-1 and FVC did not reflect the true and complete capacities of Claimant. In addition, the MVV curves indicated a poor and inconsistent effort so that Claimant had not maintained a maximal sustained effort for 12 to 15 seconds as required. DX-33. Dr. Kaplan, who is Board-Certified in Internal Medicine, Pulmonary Medicine, and Critical Care Medicine (EX-11), invalidated the study because Claimant did not exert a maximal effort as demonstrated by the fact that none of forced expiratory efforts was of sufficient

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<sup>6</sup> In the prior hearing these invalidation reports were stricken by Judge Romano. However, as noted earlier in response to Claimant's motion to strike at the hearing, this is a modification proceeding with emphasis on the most recent evidence. The reports will be considered with Claimant's objection noted.

duration. Further evidence of inconsistent effort was provided by that fact that the actual MVV (42) was much less than the expected MVV (75.6). DX-36.

Dr. Kraynak responded to the invalidation reports by disagreeing with the conclusions discussed by Dr. Levinson and Dr. Kaplan and insisted that the study was valid.

I have considered Dr. Kraynak's rebuttal opinion. Nevertheless I will accept the invalidation reports of Drs. Levinson and Kaplan on the basis of their superior credentials. See *Martinez; Dillon; Wetzel*.

| Ex. No. | Date    | Age | Ht. | FEV1 | FVC  | MVV | FEV1/FVC | Qualify |
|---------|---------|-----|-----|------|------|-----|----------|---------|
| DX-54   | 3-25-99 | 75  | 69" | 1.54 | 1.87 | 39  | 82%      | Yes     |

Dr. Kraynak interpreted this test as showing a severe restrictive defect. Claimant's cooperation and comprehension were noted as "good." This study was invalidated by Drs. Sahillioglu, Levinson, Kaplan, Hertz and Dittman. Dr. Kaplan noted this study was valid due to submaximal effort by Claimant. The forced expiration tracings revealed insufficient duration as shown by early appearance of plateau in expired volume as well as by short duration of effort. Additional evidence of submaximal effort was that the actual MVV (39) was significantly lower than the expected MVV (61.6). EX-1. Dr. Levinson invalidated the study because the entire FVC curves were not displayed and that there was evidence of exhalation before the zero point. Therefore, he opined, the FEV1 and FVC values obtained did not represent the true and complete capacities of Claimant but were an underestimation. EX-2. At his deposition on January 14, 2000, Dr. Dittman, who is Board-Certified in Internal Medicine, invalidated this study due to lack of patient effort. EX-15. Dr. Hertz, who is Board-Certified in Internal Medicine, Pulmonary Medicine, and Critical Care Medicine, invalidated the study indicating there was a lack of optimal patient effort and excessive variability in the FEV-1s. EX-13. Dr. Sahillioglu<sup>7</sup> invalidated the study due to less than optimal effort and because they were improperly performed. He noted that there was no demonstration of inspiratory effort, an inconsistent effort on the FVCs and MVVs and that a restrictive defect needed to be verified by TLC determination. DX-54.

Dr. Kraynak responded to the invalidation report of Dr. Kaplan indicating that Claimant's effort was excellent, that the tracings continued for at least five (5) seconds, and that there was good approximation between the MVV and FEV-1 showing good effort. CX-2. Dr. Kraynak responded to the invalidation report of Dr. Levinson by stating Claimant's starting point of exhalation was the zero point, the MVV tracings continued for twelve (12) seconds and approached the percentage of predicted of the FEV-1, corresponding to good effort. CX-3. Dr. Kraynak responded to the invalidation report of Dr. Sahillioglu by noting that the regulations allow inspiration to be taken from the open atmosphere. He observed Claimant's inspiratory effort and it was good. He noted

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<sup>7</sup> Dr. Sahillioglu has an ECFMG certificate and is Board-Eligible in both Internal and Pulmonary Medicine and is the Medical Director of the Pulmonary Laboratory and Respiratory Therapy at Mercy Hospital.

excellent and consistent effort with the FVCs and MVVs and stated the regulations do not require TLC confirmation of a restrictive defect. CX-24. Dr. Kraynak responded to the invalidation of Dr. Dittman at his deposition on April 28, 2000. He disagreed with Dr. Dittman and stated the study was valid. CX-35.

Dr. David Prince, who is Board-Certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine, reviewed the study and checked a box on a form indicating the “vents are acceptable” without further comment. CX-25.

Although Dr. Prince is board-certified, I attribute more weight to the opinions of Drs. Levinson, Sahillioglu, Dittman, Hertz, and Kaplan who specifically identified flaws in the tracings as opposed to Dr. Prince who merely validated the study by checking a box on a form. Without more explanation, I will not accord Dr. Prince’s validation significant weight. In *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 21 BLR 2-269 (4<sup>th</sup> Cir. 1998), the Fourth Circuit ruled that a validation of an arterial blood gas study which consisted of a checked box “lent little additional persuasive authority” to that claimant’s case. 138 F.3d at 530, 21 BLR 2-269.

I have also considered Dr. Kraynak’s rebuttal opinions. Nevertheless, I will accept the invalidation reports of Drs. Levinson, Sahillioglu, Dittman, Hertz, and Kaplan on the basis of their superior credentials to Dr. Kraynak. See *Martinez; Dillon; Wetzel*. For these reasons, I accord less weight to the opinions of Dr. Kraynak and Dr. Prince. I further credit Dr. Sahillioglu’s opinion that a diagnosis of a restrictive defect required additional measurement. As the Seventh Circuit noted in *Peabody Coal Co. v. Director, OWCP*, 972 F.2d 882, 16 BLR 2-129 (7<sup>th</sup> Cir. 1992) [*Brinkley*], “[a]lthough the tests [before it] were qualifying and conforming, they must also be valid.” 972 F.2d at 883, 16 BLR 2-129; see generally *Andruscavage v. Director, OWCP*, No. 93-3291 (3d Cir. Feb. 22, 1994) (unpub.) (Court affirms administrative law judge’s reliance on consultants who, in part, utilized this rationale). The statement by Dr. Sahillioglu is confined to the interpretation of a restrictive defect. This is an academic comment that does not directly deal with validity of the numbers reported.

| Ex. No. | Date    | Age | Ht. | FEV1  | FVC   | MVV   | FEV1/FVC | Qualify |
|---------|---------|-----|-----|-------|-------|-------|----------|---------|
| EX-3    | 8-20-99 | 75  | 69” | 1.87  | 2.84  | 48.6  | 66%      | No      |
|         |         |     |     | *2.03 | *3.00 | *64.7 | 68%      | No      |

This test was performed at Hazelton General Hospital. It was interpreted as showing a mild restrictive defect. Claimant’s cooperation was “good” both pre and post bronchodilator. Claimant’s comprehension was “fair” pre bronchodilator and “was unable to produce consistent effort post bronchodilator.

Dr. Simelaro, who is Board-Certified in Internal Medicine and Medical Diseases of the Chest (CX-11), invalidated the study because the tracings did not meet the five (5) second requirement. CX-10. Dr. Michael Venditto, who is Board-Certified in Internal Medicine and Pulmonary Diseases of the Chest (CX-13), invalidated the study because

it was difficult to read the tracings but it appeared that they did not last five (5) seconds or reach a plateau. CX-12.

I accept these unanswered invalidations and find this study unreliable, although the values are better than exceed certain of the previous results.

| Ex. No. | Date    | Age | Ht. | FEV1 | FVC  | MVV  | FEV1/FVC | Qualify |
|---------|---------|-----|-----|------|------|------|----------|---------|
| CX-1    | 8-24-99 | 73  | 68" | 1.09 | 1.19 | 47.7 | 92%      | Yes     |

This study was performed at the William H. Ressler Center and was interpreted as showing a severe restrictive defect. Claimant's cooperation was noted as "fair" and his comprehension was noted as "good."

This study was invalidated by Drs. Levinson, Kaplan, Hertz and Dittman. Dr. Levinson invalidated the study because Claimant's effort was unacceptable. Each FVC curve showed hesitancy at the onset of exhalation therefore not allowing back extrapolation of time zero. There was also gross and excessive variation in the two largest FEV-1 attempts and exhalation on FVC curves did not last a full five (5) seconds. The MVV curves indicated a poor and inconsistent effort so that Claimant had not maintained a maximal sustained effort for 12 to 15 seconds as required. EX-5. Dr. Kaplan invalidated the study due to the submaximal effort of Claimant. He noted that the best and worst FEV-1 curves varied by more than 5% and all of the FEV-1 efforts were of insufficient duration. Additional evidence of submaximal effort was demonstrated by a comparison of expected MVV (43.6) and actual MVV (47.7). The fact that the actual exceeded the expected is a physiologic improbability. EX-6. Dr. Dittman invalidated this study at his deposition on January 14, 2000. He indicated that the study was invalid due to suboptimal effort of Claimant. EX-15. Dr. Hertz invalidated the study indicating there was a lack of optimal patient effort and excessive variability in the FEV-1s. EX-13.

Dr. Kraynak responded to the invalidation study of Dr. Levinson and noted that he did not detect any hesitancy at the onset of exhalation, the two largest FEV-1 curves varied by less than 100 ml corresponding to regulations, and that the tracings continued over five (5) seconds and clearly plateau. CX-30. Dr. Kraynak responded to the report of Dr. Kaplan and stated there was good and consistent effort throughout, the two largest FEV-1 curves varied by less than 85 ml corresponding to regulations and the MVV approached the percentage of predicted of the FEV-1. CX-31. At his deposition on April 28, 2000, Dr. Kraynak responded to the invalidation of Dr. Dittman by disagreeing with his conclusions and maintaining the study was valid. CX-35.

Dr. Prince reviewed the study and checked a box on a form indicating the "vents are acceptable" without further comment. CX-40.

Although Dr. Prince is board-certified, I attribute more weight to the opinions of Drs. Levinson, Dittman, Hertz, and Kaplan who specifically identified flaws in the tracings as opposed to Dr. Prince who merely validated the study by checking a box on

a form. Without more explanation, I will not accord Dr. Prince's validation significant weight. See *Milburn Colliery Co., supra*. I have also carefully considered Dr. Kraynak's rebuttal opinions. Nevertheless, I will accept the invalidation reports of Drs. Levinson, Dittman, Hertz, and Kaplan on the basis of their superior credentials to Dr. Kraynak. See *Martinez; Dillon; Wetzel*. For these reasons, I accord less weight to the opinions of Dr. Kraynak and Dr. Prince and find this study unreliable.

| Ex. No. | Date     | Age | Ht. | FEV1 | FVC  | MVV | FEV1/FVC | Qualify |
|---------|----------|-----|-----|------|------|-----|----------|---------|
| CX-6    | 10-13-99 | 76  | 69" | 1.49 | 1.57 | 38  | 95%      | Yes     |

This study was performed at the direction of Dr. Kruk and was interpreted as showing a restrictive defect. Claimant's cooperation and comprehension was noted as "good." Drs. Kaplan, Levinson, Dittman and Hertz invalidated this study. Dr. Kaplan noted it was invalid due to submaximal and inconsistent effort by Claimant and questionable reliability of instrumentation. He noted there was excessive variation on forced expiratory tracings that exceeded the maximum allowed by the regulations. There was commencement of the forced expiration before zero indicating an incomplete recording of expired volume. Most problematic was the declining recorded expired volume as each individual forced expiration continued. This was problematic in that the device used was a volume displacement spirometer into which all expired volume is collected cumulatively. Therefore, as the forced expiratory effort continued, the amount of air exhaled should be added to the amount accumulated resulting in an upward slope until plateau is reached when no further air is exhaled. However, in this case there was a downward slope that could only be explained by a loss of expired air from the measuring device. EX-7. Dr. Levinson invalidated the study due to exhalation before the zero point causing the FEV-1 and FVC to be underestimated. He noted that Claimant's effort was unacceptable because there was excessive variation in the two largest FEV-1 curves. There was a lack of maximum airflow throughout the FVC and the MVV curves indicated variable and inconsistent effort. EX-8. Dr. Dittman invalidated this study at his deposition on January 14, 2000. He indicated that the study was invalid due to suboptimal effort of Claimant. EX-15. Dr. Hertz invalidated the study indicating there was a lack of optimal patient effort and excessive variability in the FEV-1s. EX-13.

Dr. Kraynak responded to the invalidation reports at his deposition on April 28, 2000. He disagreed with the conclusions of Drs. Kaplan, Levinson and Dittman and maintained that the study was valid. CX-35.

Dr. Prince reviewed the study and checked a box on a form indicating the "vents are acceptable" without further comment. CX-26.

Although Dr. Prince is board-certified, I attribute more weight to the opinions of Drs. Levinson, Dittman, Hertz, and Kaplan who specifically identified flaws in the tracings as opposed to Dr. Prince who merely validated the study by checking a box on a form. Without more explanation, I will not accord Dr. Prince's validation significant weight. See *Milburn Colliery Co., supra*. I have also carefully considered Dr. Kraynak's rebuttal opinions. Nevertheless, I will accept the invalidation reports of Drs. Levinson,

Dittman, Hertz, and Kaplan on the basis of their superior credentials to Dr. Kraynak. *See Martinez; Dillon; Wetzel.* For these reasons, I accord less weight to the opinions of Dr. Kraynak and Dr. Prince and find this study unreliable.

| Ex. No. | Date   | Age | Ht. | FEV1 | FVC  | MVV | FEV1/FVC | Qualify |
|---------|--------|-----|-----|------|------|-----|----------|---------|
| CX-28   | 1-4-00 | 76  | 69" | 1.63 | 2.23 | 47  | 73%      | Yes     |

This study was interpreted by Dr. Matthew Kraynak as showing a "severe restrictive defect." Claimant's cooperation and comprehension were noted as "good." Drs. Levinson, Kaplan, and Hertz invalidated this study. Dr. Levinson invalidated the study due to exhalation before the zero point causing the FEV-1 and FVC to be underestimated. He noted that Claimant's effort was unacceptable because there was excessive variation in the two largest FEV-1 curves and the MVV curves indicated variable and inconsistent effort. EX-10. Dr. Kaplan invalidated the study due to inconsistent effort by Claimant. He noted that variations in the FEV-1 and FVC curves exceeded the maximum allowed in the regulations. In addition, Claimant started forced expiration before the zero point meaning the measured volumes were less than actual since an unknown amount of air expired before start. EX-11. Dr. Hertz invalidated the study indicating there was a lack of optimal patient effort and excessive variability in the FEV-1s. EX-13.

Dr. Matthew Kraynak, who is Board-Certified in Family Medicine (CX-43), submitted a response to the invalidation by Dr. Levinson. He stated there was good effort and that the FEV-1s varied by less than 100 ml corresponding to the regulations and the MVVs showed good effort. CX-42. Dr. Matthew Kraynak responded to the invalidation by Dr. Kaplan and noted that the two largest FEV-1s varied by 75 ml corresponding to the regulations and that there was no evidence Claimant began exhalation before time zero. CX-45.

Dr. Raymond Kraynak validated the study and indicated that the 2 largest FEV-1s varied by less than 100 ml and the MVV curves varied by 10% and approach the percentage of predicted of the FEV-1 showing good effort. CX-49. Dr. Prince reviewed the study and checked a box on a form indicating the "vents are acceptable" without further comment. CX-26.

Although Dr. Prince is board-certified, I attribute more weight to the opinions of Drs. Levinson, Hertz, and Kaplan who specifically identified flaws in the tracings as opposed to Dr. Prince who merely validated the study by checking a box on a form. Without more explanation, I will not accord Dr. Prince's validation significant weight. *See Milburn Colliery Co., supra.* I have also carefully considered Dr. Matthew Kraynak's rebuttal opinions and the validation report of Dr. Raymond Kraynak. Nevertheless, I will accept the invalidation reports of Drs. Levinson, Hertz, and Kaplan on the basis of their superior credentials to Dr. Matthew Kraynak and Dr. Raymond Kraynak. *See Martinez; Dillon; Wetzel.* For these reasons, I accord less weight to the opinions of Drs. Kraynak and Dr. Prince and find this study unreliable.

| Ex. No. | Date   | Age | Ht. | FEV1  | FVC   | MVV | FEV1/FVC | Qualify |
|---------|--------|-----|-----|-------|-------|-----|----------|---------|
| EX-12   | 5-9-00 | 76  | 69" | 1.83  | 2.93  | 38  | 41%      | No      |
|         |        |     |     | *2.31 | *3.21 | *35 | 40%      | No      |

This study was performed at Hazleton General Hospital and was interpreted as showing a mild obstructive defect with improvement after bronchodilator. Claimant's cooperation and comprehension were noted to be inconsistent. Dr. Dittman invalidated this study because of inconsistent and less than maximum effort by Claimant. He noted that maximum exhalation does not begin at onset and there was evidence of hesitant flow. Dr. Dittman opined that even with less than maximum effort, Claimant produced good values indicating that lung function is not disabled or impaired. EX-12. Dr. Simelaro, who is Board-Certified in Internal Medicine and Medical Diseases of the Chest, also invalidated the study because there was too much variation in the spirometry. CX-47.

I accept these unanswered invalidations and find this study unreliable.

| Ex. No. | Date    | Age | Ht. | FEV1 | FVC  | MVV | FEV1/FVC | Qualify |
|---------|---------|-----|-----|------|------|-----|----------|---------|
| CX-44   | 5-30-00 | 76  | 69" | 1.52 | 2.15 | 48  | 70%      | Yes     |

This study was performed at the direction of Dr. Raymond Krainak and was interpreted as showing a severe restrictive defect. Claimant's cooperation and comprehension were noted as "good." Dr. Levinson invalidated this study indicating there was exhalation before the zero point therefore the FEV-1 and FVC were underestimated. In addition there was excessive variability in the two largest FEV-1 curves and the MVVs indicated variable and inconsistent effort. EX-16.

Dr. Prince reviewed the study and checked a box on a form indicating the "vents are acceptable" without further comment. CX-48.

Although both Dr. Prince and Dr. Levinson are board-certified, I attribute more weight to the opinion of Dr. Levinson who specifically identified flaws in the tracings as opposed to Dr. Prince who merely validated the study by checking a box on a form. Without more explanation, I will not accord Dr. Prince's validation significant weight. See *Milburn Colliery Co., supra*. For these reasons, I accord less weight to the opinion Dr. Prince and find this study unreliable.

Out of the twenty (20) pulmonary function studies in the record, I find the studies performed on 10-26-73 (DX-29B-23), 8-26-80 (DX-29B-23), 8-27-87 (DX-29B-10), 3-29-88 (DX-29B-26), 5-7-92 (DX-29A-6), 9-4-92 (DX-29A-23), 5-26-95 (DX-29-82), 9-2-97 (DX-10), and 11-7-97 (DX-23) to be valid, conforming, and in substantial compliance with the regulations. All of the foregoing tests, with the exception of 8-26-80 (DX-29B-23), produced non-qualifying values. As discussed above, I find that the remaining studies have been invalidated by the well-reasoned opinions of highly qualified consultants. Most of these invalidated, non-conforming studies, performed by or at the

request of Dr. Raymond Kraynak, consistently produced substantially lower values than those tests that were found to be conforming. When a conforming vent study yields values higher than those found in another invalidated study, the conforming study, given that these studies are effort dependent, is obviously more reliable than the study with lower values. Therefore, I find the conforming studies, all of which were non-qualifying except for 8-26-80 (DX-29B-23), to be more probative than those performed by Dr. Kraynak.

Moreover, I find it significant that although the recent pulmonary function studies conducted on 1-4-00 (Dr. Matthew Kraynak) and 5-9-00 (Hazelton General Hospital) were invalidated, they produced values that were significantly higher than those conducted by or at the request of Dr. Raymond Kraynak in 3-99, 8-99 and 10-99.

For these reasons, I therefore find that Claimant has failed to demonstrate total respiratory disability on the basis of the pulmonary function study evidence.

#### Arterial Blood Gas Studies

A claimant may demonstrate total disability with arterial blood gas tests which, accounting for altitude, demonstrate qualifying results as specified in Appendix C to 20 C.F.R. Part 718. 20 C.F.R. §718.204(c)(2).

The current record contains the following blood gas studies:

| Ex. No.   | Date     | Physician | Alt. | PCO2 | pO2      | Qual. |
|-----------|----------|-----------|------|------|----------|-------|
| DX-29B-23 | 10-31-79 | Evans     | --   | 33   | 83.5(R)  | No    |
|           |          |           |      | 30   | 101.4(E) | No    |
| DX-29B-12 | 8-27-87  | Cable     | *    | 34   | 92(R)    | No    |
|           |          |           |      | 36   | 69(E)    | No    |
| DX-29B-26 | 3-29-88  | Dittman   | --   | 37   | 79(R)    | No    |
|           |          |           |      | 29   | 90(E)    | No    |
| DX-29A-8  | 5-7-92   | Ahluwalia | *    | 37   | 80(R)    | No    |
|           |          |           |      | 32   | 81(E)    | No    |
| DX-29A-23 | 9-4-92   | Dittman   | --   | 41   | 70(R)    | No    |
|           |          |           |      | 38   | 74(E)    | No    |
| DX-29-82  | 5-26-95  | Dittman   | --   | 41   | 74(R)    | No    |
|           |          |           |      | 38   | 92(E)    | No    |
| DX-12     | 9-2-97   | Corazza   | *    | 31   | 75(R)    | No    |

|       |          |         |    |    |       |    |
|-------|----------|---------|----|----|-------|----|
| DX-12 | 10-15-97 | Corazza | *  | 28 | 91(E) | No |
| DX-23 | 11-7-97  | Dittman | -- | 40 | 72(R) | No |
|       |          |         |    | 41 | 67(E) | No |
| EX-3  | 8-20-99  | Dittman | –  | 36 | 77(R) | No |

\* 0 – 2999' above sea level

None of the arterial blood gas test results demonstrate total respiratory disability at Section 718.204(c)(2). I therefore find that Claimant has failed to demonstrate total respiratory disability on the basis of the blood gas study evidence.

#### Cor pulmonale

A claimant may demonstrate total disability with medical evidence of cor pulmonale with right-sided congestive heart failure in addition to pneumoconiosis. Because there is no evidence of cor pulmonale with right-sided congestive heart failure, I am unable to find that Claimant has demonstrated total disability at Section 718.204(c)(3). 20 C.F.R. §718.204(c)(3); see *Newell v. Freeman United Coal Mining Co.*, 13 BLR 1-37 (1989), *rev'd on other grounds*, 933 F.2d 510, 15 BLR 2-124 (7<sup>th</sup> Cir. 1991).

#### Medical Opinion Evidence

Claimant may demonstrate total respiratory disability by a reasoned medical opinion that assesses total respiratory disability, if the opinion is based on medically acceptable clinical and laboratory diagnostic techniques. Claimant must prove his respiratory or pulmonary condition prevents him from engaging in his “usual coal mine employment or comparable and gainful employment.” 20 C.F.R. §718.204(c)(4). Any loss in lung function may qualify as a total respiratory disability under Section 718.204(c). See *Carson*, 19 BLR at 1-21, *modified on recon.* 20 BLR 1-64 (1996).

There are eleven (11) physicians who have rendered an opinion in this case. Drs. Evans and Cable did not render an opinion regarding the issue of total disability and therefore their opinions will be accorded less weight. Drs. Dirnberger, Raymond Kraynak, Kruk, Nuschke, Corazza, and Matthew Kraynak opined Claimant suffered from a permanent, total respiratory disability that would prevent Claimant from engaging in his last mine employment. Drs. Dittman, Ahluwalia, and Hertz opined Claimant maintained the respiratory capacity to perform his last coal mine employment.

Upon review of the medical opinion evidence as a whole, I find that Claimant has not met his burden of proving total pulmonary or respiratory disability at Section 718.204(c)(4). I am mindful of Dr. Raymond Kraynak, Dr. Matthew Kraynak and Dr. Nuschke's status as treating physicians. I nevertheless credit Dr. Dittman's most recent medical opinion, that Claimant is not totally disabled, on the basis of his

credentials, the thoroughness of his report, and the clinical testing which forms some of the documentation in support of his conclusions. See *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441, 21 BLR 2-269 (4<sup>th</sup> Cir. 1997); *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989)(en banc); *Dillon v. Peabody Coal Co.*, 11 BLR 1-113 (1988). Moreover, Dr. Dittman's conclusions are supported by the detailed report of Dr. Hertz and the clinical report of Dr. Ahluwalia.

I accord less weight to the report of Dr. Dirnberger because it is not clear whether his conclusions are based on any objective diagnostic testing. Although he concluded Claimant did not have pneumoconiosis, Dr. Corazza opined Claimant had a pulmonary disability because of his finding of some restrictive pulmonary disease on a pulmonary function study in 9-97. I accord Dr. Corazza's opinion, on the issue of disability, less weight as the credible objective diagnostic testing in the record as a whole does not support a finding of a restrictive pulmonary disease. I accord the brief note of Dr. Nuschke less weight as it is not premised on any objective testing. In addition, Dr. Hertz's thorough analysis of Dr. Nuschke's treatment records effectively undermines Dr. Nuschke's conclusion regarding the presence of a disabling respiratory disease. Moreover, I accord less weight to the opinion of Dr. Kruk whose conclusion of disability is apparently based at least in part on a questionable pulmonary function study. Lastly, I accord less weight to the reports of Drs. Raymond and Matthew Kraynak. They report physical findings, such as cyanotic lips and wheezing, that are not consistent with physical findings reported by other physicians of record. Their conclusions of disability are based, at least in part, on invalidated pulmonary function studies that consistently yield lower results than those produced in other studies. For these reasons, I accord less weight to the foregoing opinions.

Reviewing the detailed findings and conclusions of Drs. Dittman, Ahluwalia and Hertz, including the extensive use of pulmonary function, arterial blood gas, and exercise tests, I find that their opinions sufficiently undermine Claimant's case so that the medical opinion evidence does not persuasively demonstrate total respiratory disability at Section 718.204(c)(4).

#### Total Respiratory Disability

After evaluating like-kind evidence under each provision of section 718.204(c), I must then evaluate all relevant evidence at Section 718.202(c), like and unlike, to find whether Claimant has established total respiratory disability. See *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987). Upon my consideration of all relevant evidence, like and unlike, including Claimant's testimony, see generally *Onderko v. Director, OWCP*, 14 BLR 1-2, 1-4 (1988); see also *Poole v. Freeman United Coal Mining Co.*, 897 F.2d 888, 894, 13 BLR 2-348 (7<sup>th</sup> Cir. 1990), I conclude that Claimant has not met his burden of establishing total disability.

I find that the non-qualifying arterial blood gas studies, the credible non-qualifying pulmonary function studies, the most recent report from Dr. Dittman, which is detailed, comprehensive and corroborated by earlier reports from Drs. Ahluwalia and Hertz

constitute “contrary probative evidence” which precludes a finding of total disability pursuant to Section 718.204(c). Again, I have accounted for multiple opinions from Claimant’s treating physicians. Nevertheless, I find, in the face of contrary probative evidence, that Claimant has failed to prove total respiratory disability by a preponderance of the evidence. Although Claimant need only establish total disability by a preponderance of the evidence, “the preponderance standard is not toothless.” See *United States v. Roman*, 121 F.3d 136, 141 (3d Cir. 1997), *cert. denied* 522 U.S. 1061 (1998).

#### Conclusion

Because Claimant has failed to prove any element of entitlement, I must conclude that he has failed to establish entitlement to benefits under the Act.

#### ORDER

The claim of Peter J. Stricek for benefits under the Act is hereby DENIED.

A  
Ainsworth H. Brown  
Administrative Law Judge

#### Attorney Fees

The award of an attorney’s fee under the Act is permitted only in cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee for services rendered to him in pursuit of this claim.

**NOTICE OF APPEAL RIGHTS:** Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing a Notice of Appeals with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Room N-2117, Frances Perkins Building, 200 Constitution Avenue, N.W., Washington, D.C. 20210.